

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013144		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/01/2014	
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK HEALTH CAMPUS				STREET ADDRESS, CITY, STATE, ZIP CODE 18275 BURR STREET LOWELL, IN 46356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>An Initial Life Safety Code Certification and State Licensure Survey for a facility with 58 SNF beds and 58 Residential beds was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 07/01/14</p> <p>Facility Number: 013144 Provider Number: 013144 AIM Number: NA</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Initial Life Safety Code and Environmental survey, the portion of Cedar Creek Health Campus which will be certified was found in compliance with Requirements for Participation in Medicare, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2-3.1-19, Environment and Physical Standards of the Indiana Health Facilities Rules for Comprehensive care facilities. The residential area which includes the Legacy wing was found in compliance with 410 IAC 16.2-5-1.5, Sanitation and Safety Standards and 16-2-5-1.6, Physical Plant Standards of the Indiana Health Facilities Rules for Residential care facilities.</p> <p>The one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in corridors, in spaces</p>			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	<p>Continued From page 1</p> <p>open to the corridor and in resident rooms. The SNF certified health care occupancy had a capacity of 58 residents and the residential areas had a capacity of 58 residents with a total capacity of 116 and had a census of 0 at the time of this survey.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</p>	K 000			